Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1993

COMMERCIAL LIFE INSURANCE COMPANY,

Petitioner,

v.

LONNIE TOLLEY,

Respondent.

COMMERCIAL LIFE INSURANCE COMPANY,

Petitioner,

v.

ALLEN SHELTON,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the substantive insuring provisions and exclusionary provisions of an ERISA welfare accidental death, dismemberment, and disability plan funded by an insurance policy should be afforded their plain meaning or whether a reviewing court should impose additional coverage conditions in the absence of any ambiguity in the plan's language.

2. Whether identical insuring clauses and exclusionary clauses contained in similar ERISA accidental death, dismemberment, and disability plans should be interpreted and applied in a uniform fashion throughout the United States.

PARTIES TO THE PROCEEDINGS IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

As plaintiffs, respondent Allen Shelton and respondent Lonnie Tolley each filed separate federal district court complaints against the petitioner Commercial Life Insurance Company setting out their respective claims for total and permanent disability under the terms of the same ERISA welfare plan in effect at the place of their employment. The respondents' employer, Nuclear Fuel Services, Inc. ("NFS") is not a party to these proceedings. The respondents' two separate cases were not consolidated at the district court level and the summary judgments were entered against each respondent on different dates.

Though briefed separately by the parties on appeal, the two cases were consolidated for oral argument before the Court of Appeals. This petition embraces the consolidated opinion of the Court of Appeals which decided the same issue presented by the appeals of the respondents. Commercial Life Insurance Company was the appellee in the proceedings before the Sixth Circuit.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED FOR REVIEW i

PARTIES TO THE PROCEEDING IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES v

OPINION BELOW 1

JURISDICTION 1

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 1

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT 15

The Interpretation of the ERISA Plan's Insuring and Exclusionary Clauses Conflicts with the Interpretation of Identical Plan Language by the Tenth Circuit Court of Appeals and With Federal Common Law Contract Interpretation Principles 15

The Sixth Circuit's Interpretation of the ERISA Plan's Insuring and Exclusionary Clauses Violates the Mandate of this Court that a Uniform Body of Federal Common Law be Developed and Applied in the Interpretation of the Substantive Provisions of ERISA-Regulated Welfare Plans 18

CONCLUSION 20

APPENDIX ..... App. 1

The Sixth Circuit Court of Appeals Memorandum Opinion entered December 17, 1993 ....App. 1

TABLE OF CONTENTS – Continued

Page

The Sixth Circuit Court of Appeals Order Denying the Petitioner's Motion to Reconsider entered February 9, 1994 .....App. 14

NFS Welfare Plan Summary Booklet Excerpts...App. 15

TABLE OF AUTHORITIES

Page

CASES

Alexander v. Erie Insurance Exchange, 982 F.2d 1153 (7th Cir. 1993) 18

Armotek Industries, Inc. v. Employers Insurance of Waussau, 952 F.2d 756 (3rd Cir. 1991) 18

Carey Canada, Inc. v. Columbia Casualty Co., 940 F.2d 1548, 291 U.S. App. D.C. 284 (1991) 18

Enterprise Tools, Inc. v. Export-Import Bank, 799 F.2d 437 (8th Cir. 1986) 18

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 19

Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1 (1983) 19

Hartford Accident & Indemnity Co. v. U.S. Fidelity and Guaranty Co., 962 F.2d 1484 (10th Cir. 1992) 18

Judwin Properties, Inc. v. U.S. Fire Insurance Co., 973 F.2d 432 (5th Cir. 1992) 18

New Castle County v. Hartford Accident and Indemnity Co., 970 F.2d 1267 (3rd Cir. 1992), *cert. denied*, 113 S.Ct. 627 (1993) 17

Nieves v. Intercontinental Life Ins. Co. of Puerto Rico, 964 F.2d 60 (1st Cir. 1992) 18

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 19

Transamerica Insurance Co. v. South, 975 F.2d 321 (7th Cir. 1992) 17

Western Heritage Insurance Co. v. Chava Trucking, Inc., 952 F.2d 651 (10th Cir. 1993) 18

Winchester v. Prudential Life Ins. Co. of America, 975 F.2d 1479 (10th Cir. 1992) 15

TABLE OF AUTHORITIES – Continued

Page

STATUTES

28 *U.S.C.* § 1254(1) 1

29 *U.S.C.* §§ 1001-1461 1

OPINION BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit in the consolidated cases of *Lonnie Tolley v. Commercial Life Insurance Company*, No. 92-6490 and *Allen Shelton v. Commercial Life Insurance Company*, No. 92-6514, (1993), was entered on December 11, 1993. A copy of the opinion is reproduced in the Appendix to this petition at App. 1. The Order of the United States Court of Appeals for the Sixth Circuit denying the petitioner's motion to reconsider was entered on February 9, 1994, and is reproduced at App. 14.

JURISDICTION

The judgment of the United States Court of Appeals for the Sixth Circuit was entered on December 17, 1993. The Order of the Court of Appeals denying the petition to reconsider was entered on February 9, 1994. This Court's jurisdiction is invoked pursuant to the provisions of 28 *U.S.C.* § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The development and application of federal common law to the resolution of disputes over employer-sponsored welfare plan insuring and exclusionary provisions come within the purview of federal courts' authority pursuant to the terms of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 *U.S.C.* §§ 1001-1461. No particular statutory provision within

ERISA nor any constitutional provision must be construed in order for this Court to define or determine the substantive federal common law principles which will govern the consideration and disposition of this case.

STATEMENT OF THE CASE

The United States Court of Appeals for the Sixth Circuit has improperly modified the insuring and exclusionary conditions of an ERISA welfare plan which provides lump sum benefits to participants who suffer accidental death, dismemberment, or total and permanent disability. In so doing, the appellate court has violated the federal common law principles which apply to contract interpretation and ERISA welfare plans and pension plans. The petitioner insists that ERISA does not require or sanction the rewriting of the insuring and exclusionary terms of an accidental death, dismemberment, and disability plan in order to afford coverage to participants where no coverage actually exists under the plain language of the plan. This case presents the issue of whether one circuit court of appeals can ignore federal common law principles recognized by the other federal courts of appeals and violate the mandate of this Court which requires that the federal courts develop a uniform body of federal common law regarding the interpretation of contractual rights and obligations which arise under welfare plans and pension plans regulated by ERISA.

The petitioner insists that clear and unequivocal insuring and exclusionary provisions which are standard in accidental death, dismemberment, and disability

ERISA plans should be uniformly interpreted and applied. The accidental death, dismemberment, and disability plan insured by the petitioner was provided for the benefit of production workers by Nuclear Fuel Services, Inc. (hereafter referred to as NFS) at its Erwin, Tennessee, plant. The plan was included as part of the employee benefits package negotiated between the company and the workers' collective bargaining agent. The company arranged for and endorsed the plan, which was funded by an insurance policy issued by the petitioner Commercial Life Insurance Company. As part of the employee benefit package, NFS also arranged for a standard long term disability plan (LTD) which provided for monthly payments to any employee who was disabled because of illness or accident for the duration of his/her total disability. That LTD plan is not involved in this litigation.

The NFS welfare plan provisions which apply to the respondent employees' claims are included in the insuring certificate set out at page eight (8) of the employer's plan summary booklet and are included in the Appendix at App. 16. The insuring clause states that the employee and his covered dependents are insured under the terms and conditions of the policy as specified in the booklet *" . . . against loss resulting directly and independently of all other causes from bodily injuries caused by accident . . . . "* The "Exclusions" section of the plan at page 10 [App. 20] specifically states that the policy does not cover any loss *" . . . caused by or resulting from . . . " [at item "D"] "Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection occurring in consequence of an accidental cut or wound; . . . . "*

Permanent total disability benefits are available only to the injured employee, and are payable only in the event that the injured employee has not been able to:

> . . . perform every duty pertaining to his/her usual occupation for a continuous period of twelve months and thereafter without interruption, his/her complete inability, because of such injuries, to engage in any occupation or employment for which he/she is fitted by reason of education, training or experience. [App. 19]

The Sixth Circuit's opinion has disregarded the federal common law principles of ERISA plan interpretation and has improperly construed the plan's language to include the requirement that the employer's company physician or the employee's treating physician must impose work restrictions on an employee before the limiting conditions of the plan's insuring and exclusionary clauses become operative. By grafting such an unusual requirement into the plan, the Court of Appeals has dramatically altered the allocation of risk, has ignored the express terms of the plan's coverage and exclusionary provisions, has transformed the accidental death, dismemberment, and disability plan into a super worker's compensation insurance plan, and has violated basic ERISA and federal common law contract interpretation principles.

Both respondents Shelton and Tolley suffered significant pre-existing bodily infirmities which pre-dated their respective claims for a lump sum $250,000.00 total and permanent disability payment under the NFS plan. The documentary evidence reviewed by the petitioner during

its claim investigation process revealed that both respondents suffered painful pre-existing back problems of a chronic, painful, and recurring nature. The existence of each respondent's bodily infirmity was documented in the file documents obtained and reviewed by the petitioner during its investigation of each claim and prior to its denying each claim. The petitioner's administrative record in each case was submitted by the parties in the respective district court cases as Joint Exhibit No. 1 in support of cross motions for summary judgment. There was no hearing or trial on the merits in either case.[1] The District Court did not determine whether the respondents' injuries were "accidental" within the meaning of the plan, nor did the Court determine the actual extent of each employee's disability. The trial court did not address the issue of whether state insurance decisional law which defined the term "accidental injury" in accidental death, dismemberment, and disability insurance policies was preempted by ERISA.

The District Court found that neither respondent was entitled to recover a lump sum $250,000.00 total disability benefit as a result of his most recent "injury" because

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[1] The District Court utilized a *de novo* review standard which applied to both the interpretation of the plan's coverage provisions and to the documentary evidence regarding the manner of injury, each plaintiff's medical condition, and the degree of permanent disability each employee may have sustained. The issue of whether either party is entitled to a hearing at which witnesses would testify and additional evidence might be introduced is not involved in this petition because of the limited nature of the District Court's findings regarding the significance of each respondent's pre-existing bodily infirmity.

each had been suffering from a significant pre-existing "bodily infirmity" which contributed to his present disability. However, the Sixth Circuit Court of Appeals reversed the District Court's conclusions and interpretation of the plan. A brief review of the factual background of each respondent's documented and known pre-existing bodily infirmity is necessary to demonstrate the Sixth Circuit's egregious divergence from accepted federal common law contract interpretation principles and from this Court's mandate for uniformity in the interpretation of ERISA welfare plan language.

Respondent Lonnie Tolley, an NFS production worker and local union president filed a claim for a total disability benefit of $250,000.00 as a result of an alleged injury he sustained in February, 1989 while intentionally lifting a four hundred (400) pound metal kettle. The record showed that Tolley had suffered a chronic and painful back infirmity for years before he filed his current claim. As early as September 28, 1982, Tolley injured his back while moving heavy drums at NFS [Ex. #1, p. 572]. On April 12, 1984, a second employer's first report of work injury showed that Tolley again strained his back while moving a loaded basket at NFS [Ex. #1, p. 574], and Dr. N.E. Hyder's examination notes [Ex. #1, pp. 216, 217] reflect that on April 25, 1984, Tolley presented himself with complaints of back pain in the lumbosacral area.

On October 3, 1984, the back pain had reoccurred in significant fashion so that the respondent had trouble getting out of bed in the mornings. In April, 1985, Tolley continued to complain to Dr. Hyder of reoccurring low back pain. By this time the pain was radiating into his right leg. The straight leg raising test was positive in the

right leg. In July, 1985, Tolley visited the doctor again after he experienced increased pain while working on his mountain cabin. The respondent's back pain persisted in spite of the flexaril and nalfon the doctor had prescribed for him. In November, 1985 Tolley required additional pain medication during union contract negotiations. Dr. Hyder's notes indicate that in 1986, a TENS unit was prescribed in an effort to relieve the back pain.

Tolley was also treated by the orthopaedic surgeons at Orthopaedic Associates of Johnson City in 1985-1986 for his chronic back and leg pain. Dr. Ted Sykes remarks in his office notes for August 6, 1985 [Ex. #1, p. 223] that "[Tolley] jumps each time I touch his back." Though Dr. Sykes thought that Tolley's back pain would subside, it did not. The respondent returned to the doctor on January 22, 1986 with " . . . a lot of pain and tenderness across the mid portion of his back . . . "

Tolley saw Dr. Sykes again on January 22, 1986, after having engaged in a dangerous, high speed pursuit of a tractor trailer which had crossed the local union's picket lines at NFS. When union president Tolley learned that a gunshot had been allegedly fired from the cab of the truck in the direction of union pickets as the truck left the NFS premises, he jumped into his automobile to give immediate chase. At some considerable risk to himself, Tolley careened through and across the unpaved highway median, drove down the wrong side of a divided highway, and blocked the truck's attempt to continue on its way to Asheville, North Carolina [Ex. #1, pp. 673-683]. In his state court personal injury action against the trucking company, Tri-State Motor Transit, Inc., and its driver, Tolley alleged that the severe jolting he received after

being forced off the road by the truck and into the highway median had aggravated his "mid back condition" from which he had suffered for several years. At paragraphs #11 and #12 of the complaint [Ex. #1, p. 682], Tolley complains of his own painful back condition:

> . . . [Tolley] avers that he now has pain in his low back and the pain has begun to radiate into his left leg again after the condition had be [sic] quiescent and non-pain producing for a period of several months . . . .

At paragraph #13 of his state court complaint, Tolley avers that he is in constant pain and has difficulty remaining on his feet at work or otherwise. Tolley personally signed the averments to his complaint [Ex. #1, p. 683]. The defendant motor carrier removed the state court complaint to the Federal District Court for the Eastern District of Tennessee, Northeastern Division on July 5, 1986. The case, CIV-2-89-165, was ultimately settled.

Respondent Tolley also resorted to chiropractic adjustment in an attempt to alleviate his continuing pain in 1986. Roger S. Herschong, D.C. gave the plaintiff the following prognosis on July 18, 1986:

> The prognosis is guarded. Remittent exacerbations of acute symptomatology occur upon minimal stress and strain.
>
> [Ex. #1, p. 236]

Tolley's medical records and judicial admissions demonstrate that he suffered from a known, significant pre-existing and obviously painful bodily infirmity which precluded his being covered for any total disability he allegedly suffered after a 1989 alleged on-the-job lifting incident.

Respondent Allen Shelton's pre-existing bodily infirmity was even more pronounced. He claimed to have been permanently and totally disabled as a result of voluntary and ordinary working movements in September, 1988. Shelton's history of significant, painful, and progressively worsening disc disease and significant pre-existing permanent disability from known bodily infirmities and an earlier back surgery clearly required that his claim for total disability based on a 1989 incident be rejected by the respondent and by the District Court. The plaintiff's company personnel file revealed that he has suffered serious back problems and disability since 1977. In a February 1, 1978, letter [Ex. #1-17, 18], Dr. Walter Chapman of the Greeneville Orthopaedic Clinic explained that Shelton, then 29 years of age, had been experiencing increasingly severe low back pain. Shelton had noticed pain after a fall at his home in July, 1977. Increasing back pain led to a myelogram which showed a ruptured disc at the L5-S1 level. Shelton underwent surgery on November 16, 1977. After doing well for several weeks, the respondent had to be re-hospitalized for recurrent low back and left leg pain. Dr. Chapman, concluded that Shelton had sustained a thirty-five percent (35%) permanent partial impairment of his lumbosacral spine as a result of his 1977 injury, surgery, and convalescence.[2] Dr. Norman Hankins, a local vocational specialist, opined in February 21, 1978, that Shelton has sustained an 80%

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[2] The petitioner insists that this significant pre-existing permanent impairment and disability constitutes a "bodily infirmity" within the meaning of the NFS welfare plan insured by the petitioner and excludes the respondent's 1988 "injury" from total disability coverage.

functional vocational disability as a result of his 1977 back injury [Ex. #1-20, 21]. In September, 1978, Shelton filed a state court lawsuit against NFS and the long term disability plan administrator, New England Life Insurance Co. alleging that he was totally and permanently disabled and thus entitled to the LTD plan's benefits of 60% of his $2,500.00 monthly salary for the rest of his life [Ex. #1-302-305]. The NFS personnel file did not indicate the outcome of the disability litigation.

Shelton's hospital records also reflected an earlier admission on January 2, 1977, because of severe back pain following an automobile accident [Ex. #1-24] and [Ex. #1-247] showed the seriousness and pre-existing nature of the respondent's back infirmity and disc disease:

> Lumbar myelogram revealed scar versus recurrent disc at L5-S1. CT scan of the lumbosacral spine reveals broad based bulging disc at the level of L5-S1. There was also a bulging disc at L4-5. . . . . Interpretation of the study reveals evidence for active denervation in the left S1/L5 distribution consistent with an acute radioculopathy.
>
> * * *
>
> FINAL DIAGNOSIS:
> 1. Back pain, aggravated by motor vehicle accident.
>
> 2. Recurrent disc disease of L5-S1.
>
> * * *
>
> PROGNOSIS: Guarded.

A return to work slip by Dr. Chapman indicates that Shelton was off work September 6, 1977, to May 18, 1982,

[nearly five (5) years] and could engage in "most normal activity" [Ex. #1-38].

The medical records available to the defendant from the plaintiff's worker's compensation suit and Johnson City's Northside Hospital confirm that petitioner Shelton is also suffering from progressive degenerative disc disease. Dr. William Kennedy, the orthopaedic surgeon who operated on the respondent in December, 1988, testified by deposition [Ex. #1-184] that X-rays and CT scans of Shelton's back which had been made in January, 1987, were essentially the same as the X-rays and a CT scan made after Shelton's September, 1988, lifting episode which is the basis of the respondent's current claim. The pre-injury 1987 scan showed evidence of degenerative disc disease and degenerative changes in the facet joints. There was no evidence suggestive of any acute change in the respondent's back condition because of his September, 1988 lifting episode.

Dr. William Kennedy, a Johnson City orthopaedic surgeon, performed a multiple level discography under local anesthesia on Allen Shelton's three lower lumbar discs on December 3, 1988 and then performed a total disc replacement at the L-5 level on December 9, 1988. By deposition [Ex. #1-194], Dr. Kennedy responded to questioning on the issue of the respondent's pre-existing disability and disease which is especially significant in this case light of the specific coverage provisions of the NFS voluntary accident insurance plan:

> Q. All right. And on May 25, 1989, did you determine whether or not he had a permanent impairment to his body?

A. Yes. Using the AMA guides to the Evaluation of Permanent Impairment, Third Edition, it was my opinion that he has a 27% permanent physical impairment to the body as a whole as a result of his back condition.

Q. Did you attribute any of that to his previous physical condition?

A. Yes. I feel that it is reasonable to attribute approximately one-third of it to the pre-existing, underlying condition that existed prior to his September, 1988, injury.

Q. So that would be 9%?

A. Yes.

Q. And did you place certain restrictions upon him?

A. Yes. Future employment should not require repeated bending, stooping or squatting, heavy lifting, working over rough terrain, excessive ladder climbing or stair climbing, vigorous jostling, such as operating machinery over rough terrain, or working with his hands raised continuously above the level of his shoulder. Ideally he should be able to control his posture with respect to sitting or standing.

Shelton's orthopaedic surgeon confirmed that the plaintiff suffered from pre-existing degenerative disc disease. In response to further deposition questioning, Dr. Kennedy stated that the plaintiff's earlier 1978 disc surgery had resulted in significant restrictions on his functional working abilities:

Q. And would it not be fair to say, Dr. Kennedy, that assuming this individual had, in fact,

> had a laminectomy in 1978, if he were your patient you would have placed the same restrictions on him then [as now]?
>
> A. Yes

Dr. William Kennedy's January 10, 1989, report letter [Ex. #1-293] also states that the plaintiff was diagnosed as having "active denervation on the left in the L-5 and S-1 distributions immediately after a January, 1987, automobile accident. The letter comports with Dr. Kennedy's deposition testimony and confirms that 1987 studies showed the plaintiff was suffering from degenerative disc disease before the September, 1988, lifting episode.

There is no doubt from the record that Shelton was acutely aware of his painful "bodily infirmity." At Ex. #1-294, Dr. Kennedy described the various types of therapy utilized by the respondent to assist him in overcoming the pain associated with his prior injuries and disc disease:

> In the past, his [Shelton's] treatment has included various heat modalities and physical therapy, which have been of variable benefit. He has used a corset without any benefit. An epidural steroid injection was done during the 1970's, apparently after the initial surgery by Dr. Chapman.

Dr. Mohamed F. Ali's letter of June 4, 1989 to the respondent's attorney [Ex. #1-299, 300] also notes the significance of Shelton's prior injuries and pre-existing bodily infirmities:

> . . . . Mr. Shelton's history is rather complicated in reference to his back, since he had his original back surgery in 1976, and he had a back injury a

> little over a year ago as a result of an automobile accident, that aggravated his pre-existing back condition.
>
> . . . . His prognosis is guarded to poor due [*sic*] to the multiplicity of factors, and the repetition of surgeries. Mr. Shelton will most likely suffer some permanent damages as a result of the above mentioned accident, but it will be rather difficult to separate the percentages resulting from his very first back surgery, as well as his motor vehicular accident, as well as his latest injury at work.

Hospital records for the respondent's 11/30/88 admission [Ex. #1-261, 262] confirmed the following diagnosis:

> FINAL DIAGNOSIS: 1. Painful degenerative disc disease at the L5.

The point of this factual discussion is that each respondent had repeatedly sought medical treatment for his bodily infirmity and each knew he had been suffering chronic and periodically acute back pain over an extended number of years. Shelton had missed nearly five (5) years of work prior to his current claim because of his pre-existing bodily infirmity. Tolley had filed and settled a personal injury action over his bodily infirmity. Whether a company or personal physician restricted either Shelton or Tolley's work activities at NFS is simply not relevant to the documented existence of each respondent's bodily infirmity or to the fact that each respondent obviously knew of his own painful back condition. Neither a physician's warning nor a work restriction is required by the plain terms of the NFS employee welfare plan.

REASONS FOR GRANTING THE WRIT

THE INTERPRETATION OF THE ERISA PLAN'S INSURING AND EXCLUSIONARY CLAUSES CONFLICTS WITH THE INTERPRETATION OF IDENTICAL PLAN LANGUAGE BY THE TENTH CIRCUIT COURT OF APPEALS AND WITH FEDERAL COMMON LAW CONTRACT INTERPRETATION PRINCIPLES.

By imposing the modification that the plan's exclusionary language does not become operative unless a physician places work restrictions on a plan participant, the Sixth Circuit has actually rewritten the plan's coverage. The appellate court's opinion effectively and irrevocably amends the specific coverage terms which require that a loss, in this case, a total and permanent disability claim, be caused by an accident, "independently" of all other causes. The opinion also eliminates the plan's exclusionary provision which exempts from coverage any loss caused by "disease" or "bodily infirmity." Such a revision of unequivocal plan language is not sanctioned by ERISA or by federal common law principles applicable to contract interpretation. The Sixth Circuit's opinion has created a conflict among the circuits with regard to the interpretation of identical insuring and exclusionary clauses in other ERISA-regulated accidental injury and disability plans and has exceeded a reviewing court's authority to construe explicit plan language.

Other ERISA plan insuring and exclusionary language which is almost identical to the NFS plan's coverage terms has been given its plain meaning by the Seventh Circuit in *Winchester v. Prudential Life Ins. Co. of*

America, 975 F.2d 1479 (10th Cir. 1992). The Seventh Circuit Court of Appeals concluded that the plan participant, who suffered a heart attack during a fire fighting training session, must have suffered from a pre-existing heart ailment, even though the ailment had been undiagnosed and unknown to the participant. The appellate court, at 975 F.2d 1487, interpreted the same "independently of all other causes" insuring clause and the "bodily infirmity" exclusionary clause to preclude the participant's widow from recovering the plan's accidental death benefits:

> We finally consider whether "[t]he injury, directly and *independently of all other causes*, resulted in the loss [emphasis added]." The policy thus makes clear that this provision excludes losses resulting even in part from preexisting conditions. This theme is echoed in the exclusions, which state that "[a]ny loss which results . . . directly or indirectly from bodily or mental infirmity or disease" is "not covered." Thus, if Mr. Winchester did have a preexisting infirmity, such as a heart condition, then his death did not result "directly and independently of all other causes."

In affirming the judgment in favor of the insurance company which insured and administered the ERISA plan, the Tenth Circuit concluded at 975 F.2d 1488:

> Finally, in our view, heart failure following planned exertion does not, in common parlance, constitute "accidental bodily injury" resulting "independently of all other causes" such as "bodily infirmity or disease."

The fact that the participant had no advance warning of any pre-existing heart ailment and did not have any

work restrictions imposed on him by any physician was irrelevant to the Tenth Circuit's interpretation of the plan's coverage terms. The same accidental injury and disability coverage and exclusionary language has now been subjected to two divergent interpretations by two separate federal circuit courts of appeal. ERISA and federal common law contract interpretation cannons do not countenance such polarized conclusions regarding the meaning of the same insuring and exclusionary provisions. The Tenth Circuit has read the plan coverage and exclusionary language as it is written and has applied it in a straightforward manner to the facts before it. The Sixth Circuit, however, dismissed the District Court's similar, plain-meaning interpretation approach, and rewrote the NFS plan's coverage terms to allow each respondent an opportunity to recover a $250,000.00 total disability lump sum benefit when that recovery should have been precluded by the clear language of the plan's insuring and exclusionary clauses.

This is not a case where the Court of Appeals believed that the particular coverage or exclusionary terms were vague or "ambiguous." If such were the case, a reviewing court might be justified in interpreting an ambiguous coverage provision liberally in favor of the plan participant. *Transamerica Insurance Co. v. South*, 975 F.2d 321 (7th Cir. 1992). However, when the wording of an insurance contract or welfare plan is explicit and the language used is clear, a majority of the circuit courts of appeal hold that the terms and conditions must be given their ordinary meaning. "Ambiguities" cannot be created in order to expand clearly worded restricted conditions of coverage. *New Castle County v. Hartford Accident and*

Indemnity Co., 970 F.2d 1267 (3rd Cir. 1992), *cert. denied*, 113 S.Ct. 1846; *Alexander v. Erie Insurance Exchange*, 982 F.2d 1153 (7th Cir. 1993); *Hartford Accident & Indemnity Co. v. U.S. Fidelity and Guaranty Co.*, 962 F.2d 1484 (10th Cir. 1992), *cert. denied, El Paso Natural Gas Co. v. Hartford Accident and Indemnity Corp.*, 113 S.Ct. 411 (1992); *Nieves v. Intercontinental Life Ins. Co. of Puerto Rico*, 964 F.2d 60 (1st Cir. 1992), opinion amended; *Judwin Properties, Inc. v. U.S. Fire Insurance Co.*, 973 F.2d 432 (5th Cir. 1992); *Armotek Industries, Inc. v. Employers Insurance of Waussau*, 952 F.2d 756 (3rd Cir. 1991); *Western Heritage Insurance Co. v. Chava Trucking, Inc.*, 952 F.2d 651 (10th Cir. 1993); *Carey Canada, Inc. v. Columbia Casualty Co.*, 940 F.2d 1548, 291 U.S. App. D.C. 284 (1991); *Enterprise Tools, Inc. v. Export-Import Bank*, 799 F.2d 437 (8th Cir. 1986).

The Sixth Circuit expressly held in this case that the insuring and exclusionary clauses were not ambiguous. See App. 6-7. There is simply no justification for the appellate court to have deviated from established federal common law contract interpretation principles or from the mandate of this Court that the developing body of federal common law which regulates substantive rights under ERISA-regulated welfare plans be uniform throughout the nation.

THE SIXTH CIRCUIT'S INTERPRETATION OF THE ERISA PLAN'S INSURING AND EXCLUSIONARY CLAUSES VIOLATES THE MANDATE OF THIS COURT THAT A UNIFORM BODY OF FEDERAL COMMON LAW BE DEVELOPED AND APPLIED IN THE INTERPRETATION OF THE SUBSTANTIVE PROVISIONS OF ERISA-REGULATED WELFARE PLANS.

The Sixth Circuit's opinion erodes the mandate of this Court that the federal courts develop a body of

"federal common law of rights and obligations under ERISA-regulated plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) quoted with approval in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). See also *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24, n.26 (1983). The Sixth Circuit's interpretation of the NFS welfare plan is antagonistic to the universally recognized federal common law cannons of contract interpretation and creates divergency instead of uniformity in the developing body of ERISA federal common law. The manifest purpose of ERISA, as recognized by previous opinions of this Court, requires that the Sixth Circuit's decision be reviewed so that uniformity in the interpretation of ERISA plan substantive provisions can be firmly established and maintained.

The NFS accidental injury and disability plan insured by the defendant is not a worker's compensation plan and is not restricted to accidental injuries which may occur on any particular job site. The Sixth Circuit's eccentric requirement that a physician must actually place written restrictions on a plan participant's work activities is an unwarranted amendment of plan coverage and is not justified by any federal common law cannon of contract interpretation. There is no support for the Sixth Circuit's insistence that a plan participant should be "warned" [App. 9] he has a pre-existing "bodily infirmity" since there is no such requirement in the plan, since the exclusionary clauses are not conditioned on any such "warnings," and since both respondents in this case were well aware of their own pre-existing painful back conditions. To allow the appellate court to disregard clear plan language and extend insurance coverage for an injury or

disability which is expressly excluded on the face of the plan is to sanction the potential for haphazard and idiosyncratic interpretations and amendments of every ERISA welfare plan. Federal courts should not get into the business of rewriting ERISA plan coverages and exclusions.

CONCLUSION

For the foregoing reasons, the petitioner Commercial Life Insurance Company, prays that this Court grant its petition and issue a writ of certiorari to the Sixth Circuit Court of Appeals.

Respectfully Submitted,

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RECOMMENDED FOR PUBLICATION

NOS. 92-6490, 92-6514

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

LONNIE TOLLEY,

Plaintiff-Appellant,

v.

COMMERCIAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

ALLEN SHELTON,

Plaintiff-Appellant,

v.

COMMERCIAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF TENNESSEE

(Filed Dec. 17, 1993)

NOT RECOMMENDED FOR FULL TEXT PUBLICATION

Sixth Circuit Rule 24 limits citation to specific situations. Please see Rule 24 before citing in a proceeding in a court In the Sixth Circuit. If cited, a copy must be served on other parties and the Court. This notice is to be prominently displayed if this decision is reproduced.

BEFORE: MARTIN and SUHRHEINRICH, Circuit Judges; CELEBREZZE, Senior Judge.

PER CURIAM. In these consolidated actions under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), plaintiffs Allen Shelton and Lonnie Tolley challenge the district court's orders granting summary judgment in favor of defendant commercial Life Insurance Company. We have jurisdiction under 28 U.S.C. § 1291. For the following reasons, we **VACATE** the district court's order granting summary judgment and **REMAND** for de novo consideration of the plan and the plaintiffs' entitlement to benefits under the plan.

I.

Plaintiffs Allen Shelton ("Shelton") and Lonnie Tolley ("Tolley") both work for Nuclear Fuel Services ("NFS"), a manufacturer of fuel for nuclear submarines. Both suffered on-the-job back injuries which disabled them from working for NFS. Plaintiffs now seek $250,000 lump sum disability benefits under the Voluntary Accident Insurance Plan for Hourly Employees ("the Policy") provided by NFS through defendant Commercial Life Insurance Company ("Commercial Life"). The Policy is a welfare benefit plan governed by ERISA. Commercial Life denied plaintiffs, claims on alternative bases. First, Commercial Life stated that plaintiffs were not "totally disabled" under the Policy, which defines that term as being "unable to engage in each and every occupation or employment for compensation or profit for which you are reasonably qualified by reason of your education, training or experience." Second, Commercial Life found that plaintiffs' injuries were not "loss[es] resulting directly

and independently of all other causes from bodily injuries caused by accident" for two reasons. First, plaintiffs had preexisting back conditions and the Policy excluded coverage for loss caused by or resulting from . . . bodily infirmity. . . . " Second, the precipitating circumstances were not accidents.

Plaintiffs brought separate suits under ERISA, and the parties sought summary judgment. In both cases, the district court granted summary judgment to Commercial Life finding that plaintiffs' prior back injuries precluded coverage for their current injuries. Both plaintiffs appealed and their cases were consolidated on appeal. The specific facts of each case follow.

A. Allen Shelton

Shelton was a chemical operator at NFS, where he worked in the manufacturing process. He has suffered back problems since 1977, when he had surgery for a ruptured disc. He returned to work without restrictions and worked until January 1987, when he suffered another back injury due to an automobile accident. Shelton returned to work in February 1987, after he was released with no restrictions. In September 1988, Shelton suffered another back injury while lifting a 60 to 70 pound tube at NFS. Since being treated for his most recent injury, Shelton has not worked.

On August 2, 1989, Shelton filed a claim for benefits under the Policy, which provides:

> PERMANENT TOTAL DISABILITY (Employee Only)

> If injury occurring after the effective date of coverage and commencing within 365 days after an accident causes continuous total disability for 12 continuous months and you are judged to be permanently and totally disabled (unable to engage in each and every occupation or employment for compensation or profit for which you are reasonably qualified by reason of your education, training or experience), you will be paid the Principal Sum [$250,000] less any amount paid or payable under the policy as the result of the same accident.

The Policy excludes from coverage that loss which results from "illness or disease," and insures the employee against "loss resulting directly and independently of all other causes from bodily injuries caused by accident." On December 29, 1989, and February 9, 1990, Commercial Life denied the claim by letter for the reasons previously stated.

B. Lonnie Tolley

Tolley was a production operator at NFS. Like Shelton, he had suffered previous back problems. In 1982, he injured his back lifting heavy drums. In 1984, he strained his back moving a loaded basket and within two weeks sought medical help for back pain. In 1986, Tolley's back problems were aggravated during an automobile accident. On February 28, 1989, he suffered the precipitating injury while he and another employee were moving a tank which weighed approximately four hundred pounds. He has not worked since shortly after the injury.

On June 25, 1990, Tolley filed a claim for benefits under the same policy provision as Shelton. On September 10, 1990, Commercial Life denied benefits for the reasons previously indicated.

II.

Because Commercial Life has no discretionary power under the Policy, the district court reviewed its denial of benefits de novo pursuant to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The district court's review is limited to the record before the administrator at the time the determination was made. *Perry v. Simplicity Eng'g*, 900 F.2d 963 (6th Cir. 1990).

Now before the court are issues pertaining to the construction of the policy. The question of whether the provisions are ambiguous is a question of law requiring de novo review. *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1003 (6th Cir. 1993). Plaintiffs contend that the provisions are ambiguous and that the court should employ the rule of *contra proferentum* thus construing the ambiguous policy terms against the insurer. If two different interpretations are applicable to a policy, the rule provides that the interpretation most favorable to the insured will be adopted. A. Windt, *Insurance Claims and Disputes* § 6.02, at 281-82 (footnote omitted). Defendant correctly asserts that the rule is preempted.

Under *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 429-30 (6th Cir. 1989), in deciding whether ERISA preempted a state breach of contract action, we held that Kentucky's rule of *contra proferentum* was preempted and not "saved." *McMahan* governs the issue here

and we find that any state rule of construction likewise is preempted and not "saved." *McMahan* did not address the application of the rule as a matter of federal law pursuant to the Congressional directive to form a "federal common law of rights and obligations under ERISA. . . . "

Under federal common law, the court resolves ambiguity through traditional methods of contract interpretation. *Boyer*, 986 F.2d at 1005. One such method is the rule of *contra proferentum* which is followed in all fifty states as well as the District of Columbia. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990) (citations omitted). Therefore, the rule of *contra proferentum* may be applicable as a matter of federal common law. *See Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98, 107 (2d Cir. 1991) (adopting rule as federal common law); *Kunin*, 910 F.2d at 539-40 (holding that the rule applied either as "saved" state law or as federal common law). *But see Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990), *cert. denied*, 111 S. Ct. 2872 (1991) (quoting *Wallace v. Firestone Fire & Rubber Co.*, 882 F.2d 1327, 1329 (8th Cir. 1989) (quoting *Bruch*, 489 U.S. at 112). Absent an ambiguous term in the Policy, there is no need to apply any rule of construction. *See Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990). A term is ambiguous if it is subject to reasonable alternative interpretations. *Mellon Bank, N.A. v. Aetna Business Credit, Inc.*, 619 F.2d 1001, 1011 (3d Cir. 1980).

After reviewing the Policy, we find no need to decide whether to apply the rule. Although the term "bodily infirmity" is not defined in the Policy, an infirmity as

used in the context of accident insurance means a "defective condition of a substantial character which in some material degree impairs the physical condition and health of the applicant, and increases the chance of death, sickness, or accident against which the insurance company is asked to issue insurance." 29 Am. Jur. Reved. Ins. § 749. Thus, a temporary ailment or disorder would not constitute a "bodily infirmity." Nor would a condition that caused marginal impairment. Although the application of this term to particular circumstances may be difficult, the term is not ambiguous.

A similar requirement as to degree has been read into the other provision implicated in the district court's decision – that losses must result "directly and independently of all other causes from bodily injury. . . . " In *Adkins v. Reliance Standard Life Ins. Co.*, 917 F.2d 794 (4th Cir. 1990), the court used federal common law to construe a policy containing the same language as the policy here. It held that coverage for losses "resulting directly and independently of all other causes from bodily injury caused by accident" does not exclude preexisting infirmity or disease unless the infirmity "substantially contributed to disability or loss." *Id.* at 797 (citing *Colonial Life & Accident Ins. Co. v. Weartz*, 636 S.W.2d 891 (Ky. Ct. App. 1982)). In reviewing other courts' construction of this provision, the *Adkins* court found that one group of cases permitted recovery even if there was a preexisting disease or infirmity on the ground that it was a remote cause. *Id.* at 796. Another group denied recovery if the preexisting condition contributed to the precipitating cause. *Id.*

Here, because the policy also excluded loss resulting from illness or disease, the first line of cases are inapplicable. Because a reasonable construction of the policy language would not ignore the exclusions, we find that the construction adopted in *Adkins* applies here. We agree the Adkins construction "promotes the interests of the employees and beneficiaries" thereby serving the purpose for which ERISA was enacted. *Bruch*, 489 U.S. at 113 (quoting *Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85 (1983)). Accordingly, it is not necessary to resort to the rule of *contra proferentum*.

III.

A.

As to plaintiff Shelton, the district court held that his preexisting back condition, degenerative disc disease, constituted a "bodily infirmity" which contributed to his disability and that "under the plain language of the policy, his injury of September, 1988, was not caused 'directly and independently of all other causes, by his lifting of the heavy object." In reaching its conclusion, the district court relied on the deposition testimony of Shelton's orthopedic surgeon wherein he stated that there was a "reasonable probability" that Shelton's "disc was in a weakened condition and vulnerable to this type of injury." Dr. Kennedy also testified that he would attribute one-third of the existing injury to Shelton's preexisting underlying condition. Further, Kennedy noted that the x-rays and CT scans of Shelton's back in January of 1987, were essentially the same as those made after the September 1988, lifting episode. Finally, he stated that although

the plaintiff's return to a full range of activity after his earlier surgery created some inferences favorable to plaintiff's claim, the underlying weakness was not eliminated.

Although this testimony would support the district court's finding, the record is also clear that after Shelton's surgery for a ruptured disc, he returned to work without restrictions and worked until he was injured in an auto accident. Shelton again returned to work without restrictions and worked for over one and one-half years until the lifting incident occurred. After each previous injury Shelton received clearance from a company doctor to return to his job without restriction. Implicit in the district court's holding is the legal conclusion that the releases in no way insulated the first injury from the second or the second from the third. Once a doctor permitted Shelton to engage in the very work that resulted in his injury, we decline to find that either of the previous injuries constituted a "physical infirmity." The medical releases distinguish this case from *Lingerfelt v. Nuclear Fuel Servs. Ins.*, 1991 U.S. App. LEXIS 1822, at *9-*10 (6th Cir. Feb. 5, 1991) (unpublished) in that the doctor released the employee for work with a warning to be "careful with his back for the rest of his life because of his multiple level painful degenerative disc disease." Had the previous injury materially impaired the plaintiff's health, he would have been advised of that by the treating physician. Here, the record contains no warnings by treating physicians to put the plaintiffs on notice.

In addition, ERISA requires that participants be furnished with a plan description written in a "manner

calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a)(1). This provision provides an alternate basis for vacating the district court's order. The average participant would not understand from reading the plan description that clearance from a doctor to return to work involving manual labor would be insufficient to cut the link between one occurrence of back strain and another injury. Consequently, a participant would reasonably expect coverage under the plan if he were disabled by an accident.

B.

As to plaintiff Tolley, the record contains no information regarding medical releases. Tolley suffered "minor changes consistent with osteoarthritis." Whether this condition is related to the precipitating injury is not indicated and the degree to which any previous injury effected that last is not known. As *Lingerfelt* recognized, when a disease contributes only negligibly to the injury, coverage may be available. Tolley's previous back problem in 1986, was diagnosed as acute strain and sprain. Although the treating physician noted that Tolley experienced "remittent exacerbations of acute symptomatology" upon "minimal stress and strain," it is undisputed that Tolley returned to work and was injury free until the lifting incident.

We disagree with the district court that it is "apparent from the totality of the evidence in the record that his disability was caused, at least in part, by his pre-existing [sic] back condition which is certainly a 'bodily infirmity.' " The existence of osteoarthritis does not necessarily

signify a condition which increased the likelihood of the injury. We are not free to apply a layman's prognosis of the condition when the term is used by a medical expert in the context of a professional opinion. Similarly, the mere occurrence of previous back injuries cannot be equated with the existence of a preexisting infirmity. We therefore conclude that the records presented to the administrator are inadequate to support a finding that either plaintiff suffered a preexisting bodily infirmity. Accordingly, consideration by the district court of the other arguments presented by the parties in this matter is necessary.

IV.

Plaintiffs further argue that Commercial Life is estopped from denying disability benefits because it violated ERISA, 29 U.S.C. § 1133 by not setting forth reasons for the denial of benefits.[1] We disagree.

Section 1133 does require written notice of a denial under a welfare benefit plan setting forth the specific reasons for denial.[2] Federal regulations provide that the

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[1] Plaintiffs have failed to include their briefs in support of their motions for summary judgment in their joint appendices; therefore, we are unable to determine whether this issue was presented to the district court. The district court did not address this issue.

[2] Section 1133 provides:

> In accordance with the regulations of the secretary, every employee benefit plan shall – (1) Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been

notice under § 1133 must contain the specific reason for denial, references to specific plan provisions on which the denial is based, a description of additional materials necessary to perfect a claim, and the steps necessary for a claimant to obtain review of the denial. 29 C.F.R. § 2560.503-1(f). Here, the denial letters provided the reasons for denial and referred to specific policy provisions, but they failed to explain the steps by which plaintiffs could have sought review of their claims. Thus, the letters did not comply with the requirements of the regulations.

Not all procedural defects require us, however, to overturn a denial of benefits, but "significant error[s] on . . . question[s] of law . . . require[ ] that the decision to deny benefits be overturned." *VanderKlok v. Provident Life and Accident Ins. Co.*, 956 F.2d 610, 616 (6th Cir. 1992); *Wolfe v. J.C. Penney Co., Inc.*, 710 F.2d 388, 393 (7th Cir. 1983) (cited with approval in *VanderKlok*). In *VanderKlok*, the insurance company failed to set forth the reasons for denial of a claim, and we remanded for reconsideration after the plaintiff has submitted new evidence pertaining to his claim. *VanderKlok*, 956 F.2d at 617. Here, however, plaintiffs were notified of the deficiencies in their claim, and nothing further was required to perfect the claim; thus, no new evidence is required. We conclude that although Commercial Life violated the strict letter of

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denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

§ 1133 and its regulations, it did provide plaintiffs with the necessary information to understand why their claims were being denied, the true purpose of § 1133. Thus, this error was not "significant" and does not require reversal.

V.

For the foregoing reasons, we REMAND to the district court for consideration of the other basis upon which Commercial Life denied benefits.

Nos. 92-6490/6514

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

LONNIE R. TOLLEY; ALLEN SHELTON,	)	
Plaintiffs-Appellants,	)	ORDER
v.	)	(Filed Feb. 9, 1994)
COMMERCIAL LIFE INSURANCE COMPANY OF NEWARK, NEW JERSEY,	)	
Defendant-Appellee.	)	

BEFORE: MARTIN and SUHRHEINRICH, Circuit Judges; and CELEBREZZE, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF
THE COURT

/s/ Leonard Green
Leonard Green, Clerk pe

Voluntary
Accident
Insurance
Plan

FOR HOURLY EMPLOYEES OF:

NUCLEAR
FUEL
SERVICES,
INC.

[logo]

* * *

AMOUNTS OF PRINCIPAL SUM APPLICABLE

EMPLOYEE:
As stated under "Employee's Amount of Insurance" on the enrollment form.

SPOUSE:
(1) 50% of the Principal Sum applicable to the employee if there are no dependent children insured at the time of loss; or
(2) 40% of the Principal Sum applicable to the employee if there are dependent children insured at the time of loss.

DEPENDENT CHILDREN:
10% of the Principal Sum applicable to the employee will be provided for each eligible child if there is a spouse. If there is no spouse, 15% of the Principal Sum applicable to the employee will be provided for each eligible child, not to exceed a maximum of $30,000.

THE COMPANY HEREBY CERTIFIES that the employee whose enrollment form is attached (herein called the Insured) and if family coverage has been requested on such enrollment form, his spouse (herein called Insured

Spouse) and his dependent children (herein individually called Insured Child) are insured under and subject to the terms, conditions and limits of liability of the policy as specified above under Amounts of Principal Sum Applicable, against loss resulting directly and independently of all other causes from bodily injuries caused by accident occurring while this policy is in force as to an insured person (herein called such injuries).

The insurance described in this certificate automatically terminates at the end of the period for which premium has been paid if any of the following occur: with respect to all insured persons, when the Insured ceases to be an eligible employee as defined in the policy; with respect to the Insured Spouse or Insured Child, when such insured person ceases to be a spouse or unmarried dependent child of the Insured; with respect to an Insured Child, upon attainment of age 19 or 23 if attending an accredited school or college on a full-time basis, and dependent upon the Insured for support and maintenance; or the Policyholder or Company terminates the policy as provided therein.

This certificate replaces any and all certificates previously issued to the Insured with respect to the policy above identified.

A & H UN 12072

GSR-CERT. CALIF – Printed in U.S.A.

DESCRIPTION OF COVERAGE

COVERAGE A – LOSS OF LIFE, LIMB OR SIGHT INDEMNITY: If such injuries shall result in any one of the following specific losses within one year from the

date of accident the Company will pay the benefit specified as applicable thereto, based upon the Principal Sum; provided, however, that not more than one (the greater) of such benefits shall be paid with respect to injuries resulting from any one accident.

For Loss of Life.....The Principal Sum
For Loss of –
Both Hands or Both Feet or
Sight of Both Eyes .....The Principal Sum
One Hand and One Foot .....The Principal Sum
One Hand or Foot and
Sight of One Eye.....The Principal Sum
Speech and Hearing.....The Principal Sum
One Leg or One Arm . .One-Half the Principal Sum
Either Hand or Foot. . . .One-Half the Principal Sum
Speech or Hearing .....One-Half the Principal Sum
Sight of One Eye.....One-Half the Principal Sum
Thumb and Index Finger of the
Same Hand .....One-Quarter the Principal Sum

"Loss" shall mean with regard to hands and feet, actual severance through or above wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight; with regard to leg or arm, actual severance through or above knee or elbow joint; with regard to thumb and index finger, actual severance through or above metacarpophalangeal joint; with regard to speech and hearing, entire and irrecoverable.

COVERAGE B – COMMON DISASTER

If Plan II is selected to cover both employee and spouse and both employee and spouse die as a result of injuries from the same accident within 90 days of the accident, the

Principal Sum payable for loss of the spouse will be increased to equal that payable for the loss of the employee.

COVERAGE C – EDUCATION BENEFIT

If injury sustained by an Insured person shall result in loss of life, within 365 days of the date of accident, the Company shall pay an Education Benefit equal to the lesser of 2% of the Insured person's Principal Sum or the maximum of $2,500 annually, to any covered dependent who is eligible for the Education Benefit. The Principal Sum shall be as determined in accordance with the enrollment form as applicable to the Insured person.

A covered dependent shall be eligible for the Education Benefit if such dependent is enrolled as a full-time student in any institution of higher learning beyond the 12th grade level, or, is in the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of loss.

The Education Benefit shall be payable annually for a maximum of four consecutive annual payments provided that:

(a) The covered dependent remains enrolled as a full-time student; and

(b) The benefit shall be payable annually for a maximum of four consecutive annual payments provided that:

The first payment will become payable on the date both the benefit for loss of life becomes payable and the date the Company receives proof that the covered dependent is attending an institution of higher learning as a full-

time student. Subsequent payments will become payable for each successive school year on the date the Company receives proof that the covered dependent is attending an institution of higher learning as a full-time student.

If, at the time of loss, the Insured person has no covered dependent eligible for the Education Benefit, the Company shall pay an additional amount of $1,000 to the designated beneficiary.

COVERAGE D – PERMANENT TOTAL DISABILITY (Not Applicable to Dependents)

If such injuries, within 365 days after the date of accident, shall cause "Permanent Total Disability" of the insured, the Company will pay, subject to due proof of loss of Permanent Total Disability, the amount of the Principal Sum less the total of any other payments made.

"Permanent Total Disability" as used herein, means the Insured's complete inability, because of such injuries, to perform every duty pertaining to his/her usual occupation for a continuous period of twelve months and thereafter, without interruption, his/her complete inability, because of such injuries, to engage in any occupation or employment for which he/she is fitted by reason of education, training or experience.

If the Insured dies before receiving payment of the Principal Sum amount, the balance remaining unpaid at the time of his/her death shall be paid in accordance with the Payment of Claims Provision.

EXCLUSIONS

This policy does not cover loss caused by or resulting from any one or more of the following:

A. Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;

B. Declared or undeclared war or any act thereof;

C. Accident occurring while an insured person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty);

D. Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection occurring in consequence of an accidental cut or wound;

E. Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,

(1) while being used for any test or experimental purpose; or

(2) while an insured person is operating, learning to operate or serving as a member of the crew thereof; or

(3) while being operated by or for or under the direction of any military authority, other than transport-type aircraft operated by the Military Airlift Command (MAC) of the United States of America or the similar air

(4) transport service of any other county; or any such aircraft or device which is owned or leased by or on behalf of the Policyholder or any subsidiary or affiliate of such Policyholder.

PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company within thirty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured person and insured dependent or the beneficiary to the Company at Newark, N.J., or to an authorized agent of the Company, with information sufficient to identify the insured person shall be deemed notice to the Company.

Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimants such forms as are usually furnished by it for filing proofs of loss.

If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment.

If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured person. Any other accrued indemnities unpaid at the insured person's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured person.

Proofs of Loss: Written proof of loss must be furnished to the Company at its said office within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this policy will be paid immediately upon receipt of due written proof of such loss.

* * *